Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

June 14, 2023

[redacted]
JUNIPER VILLAGE AT SOUTH HILLS LLC
1320 GREENTREE ROAD
PITTSBURGH, PA, 15220

RE: JUNIPER VILLAGE AT SOUTH HILLS
1320 GREENTREE ROAD
PITTSBURGH, PA, 15220
LICENSE/COC#: 45265

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/08/2023, 03/09/2023, 03/13/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *JUNIPER VILLAGE AT SOUTH HILLS* **Licen e #**: *45265* **Licen e Expiration**: *07/12/2022*

Address: *1320 GREENTREE ROAD, PITTSBURGH, PA 15220*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *JUNIPER VILLAGE AT SOUTH HILLS LLC*

Address: *1320 GREENTREE ROAD, PITTSBURGH, PA, 15220*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *07/11/1996* **I ued By**: *Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *83* **Waking Staff**: *62*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/13/2023*

Inspection Dates and Department Representative

03/08/2023 On Site [redacted]
03/09/2023 On Site [redacted]
03/13/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *96* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Wellsprings* **Capacity**: *26* **Residents Served**: *12*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *57*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *26* **Have Physical Disability**: *1*

Inspections / Reviews

03/08/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/01/2023*

Inspections / Reviews *(continued)*

04/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/13/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/05/2023*

05/16/2023 - POC Submission

Submitted By [redacted] **Date Submitted:** *06/13/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/23/2023*

06/14/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/13/2023*

Reviewer [redacted] **Follow-Up Type:** *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 3/8/23 at 9:30 a.m., the home's license posted in the foyer at the front entrance expired 7/12/22.

Plan of Correction ***Accept (- 05/16/2023)***

The following corrective action was completed at time of survey on 3/8/2023. The check was cashed but not license was sent. A email was sent to DHS and
and the 2 forms were faxed to DHS.
on 3/8/2023 identified staff was educated on the importance of sending in all documentation for license to be in compliance.
starting on 5/10/2022 the designated staff person will check monthly to ensure that the current license is posted in a conspicuous and public place in the personal care home. documentation will be kept.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Implemented (- 06/14/2023)

42l - Personal Clothing

2. Requirements

2600.
42.l. A resident has the right to furnish his room and purchase, receive, use and retain personal clothing and possessions.

Description of Violation

Multiple resident-home contracts indicate, "you, your family or responsible party are not permitted to install or maintain any video, audio, or other surveillance equipment in your suite without first providing prior written request to the residence ED advising of the intent to use such equipment...", including the following:

- *resident #1's contract, dated /22*
- *resident #2's contract, dated 22*
- *resident #3's contract, dated /22*

Plan of Correction ***Accept (- 05/16/2023)***

On 5/12/2023 a designated staff person reviewed all contract to ensure that any resident contract signed before January 2023 would be sent an amendment to ensure compliance with regulation 2600.42l . Documentation will be kept.
On 5/22/2023 a designated person will send out the amendment with the June invoice to residents POA to ensure compliance with regulation 2600.44l. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *05/16/2023*

Implemented (- 06/14/2023)

42r - Visitation

3. Requirements

2600.
42.r. A resident has the right to receive visitors for a minimum of 12 hours daily, 7 days per week.

42r - Visitation *(continued)*

Description of Violation

From approximately 1/17/23 through 1/23/23, the home restricted visitation due to an outbreak of COVID-19; however, this suspension of regulation 42(r) was lifted effective 11/1/22, and, per guidance issued 1/20/23, the Department's Regional Office was not contacted for approval of this temporary restriction. Multiple residents were denied visitors, including resident #3.

Plan of Correction ***Accept (- 04/28/2023)***

The facility disagrees with the issuance of this citation as the violation cited is not correct. The facility evidenced compliance by notifying the inspector by phone as soon as the results of covid testing was completed on the 2 residents in question and stating that we will be temporarily limiting visitation per resident safety needs. in compliance with public health order to maintain safety of residents and infection control standards.
For the purpose of compliance and not as an admission of any wrongdoing whatsoever, the following correction is provided:
In the event of an adverse health condition or scenario, the E.D. or designated staff person will notify the PA Department of Human Services Regional Office for approval prior to executing required safety actions. The E.D. or designated staff person will maintain documentation of this notification along with the Regional Office response.

Licensee's Proposed Overall Completion Date: *04/19/2023*

Implemented (- 06/14/2023)

51 - Criminal Background Check

4. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, the home's administrator, was hired 21; however, the home did not complete a criminal history background check unti 22.

Plan of Correction ***Accept (- 05/16/2023)***

On 3/14/2023 a designated staff person reviewed all current staff records to ensure a criminal background check was completed and placed in the staff record prior to staff start date. Documentation kept.
On 3/14/2023 identified staff was educated on the importance of completing a background check prior to start date. Documentation kept.
On 5/9/2023 A tracking system will be developed and implemented to ensure new staff persons have all required documentation, including a criminal background check performed by the Pennsylvania State Police. If new staff has not been a Pennsylvania resident for the past 2 years, an FBI check will also be conducted to ensure criminal history and hiring policies are in accordance with the older Adult Protective Services Act and PA Code Chapter 15. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Implemented (- 06/14/2023)

65g - Annual Training Content

5. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff person B, hired [redacted]/19, did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert and in the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year 2022.

Staff person C, hired[redacted]21, did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations and the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year 2022.

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

On 3/14/2023 staff person B completed training in fire safety by a fire safety expert. Documentation kept.
On 3/16/2023 staff person B and Staff person C completed training for the Older Adult Protective Service Act. Documentation kept.
On 3/16/2023 staff person C completed training in emergency preparedness
Documentation kept.
On 3/13/2023 a designated staff person reviewed all staff records to ensure that all staff members have completed the required training in accordance with 2600.65g Documentation kept.
Within 30 days of plan of correction: A tracking system will be developed and implemented to ensure that all staff members are compliant with the required training in accordance with 2600.65g during the established training year. Documentation will be kept. This will be reviewed quarterly at the Quality Management Meetings.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented ([redacted] - 06/14/2023)

85a - Sanitary Conditions

6. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/8/23 at 10:17 a.m., there were approximately 30 cigarette butts lying on the ground to the left of the front door.

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

The following corrective action was completed at time of survey on 3/8/2023. All cigarette butts were removed from the ground, left of the front porch.
On 3/14/2023 the identified staff were educated on the importance of the walk around of building to ensure that sanitary conditions are maintained. Documentation kept.
Compliance will be monitored during daily community rounds by designated staff person.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented ([redacted] - 06/14/2023)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 3/8/23 at 9:55 a.m., the lid on the slim jim trash can in the main kitchen was broken, could not close on one side, and was filled with trash.

Plan of Correction ***Accept (- 04/28/2023)***

The following corrective action was completed at time of survey on 3/8/2023. the lid on the slim jim trash can was repaired.
On 3/14/2023 identified staff was educated on on kitchen garbage cans need to have a lid on it at all times. Documentation kept.
Compliance will be monitored during daily community rounds by designated staff person..

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented (- 06/14/2023)

89b - Hot Water Temperature

8. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 3/8/23 at 2:34 p.m., the hot water temperature in resident bedroom measured 133.3 degrees Fahrenheit, and on 3/13/23 at 11:52 a.m., the water temperature 124.7 degrees Fahrenheit.

On 3/13/23 at 9:21 a.m., the hot water temperature in resident bedroom measured 128.3 degrees Fahrenheit, and at 11:57 a.m., measured 125.4 degrees Fahrenheit.

REPEAT VIOLATION: 9/28/2021 et al.

Plan of Correction ***Accept (- 04/28/2023)***

On 3/14/2023 a designated staff person checked water temperatures in bedroom which measured 118.2 degrees fahrenheit and bedroom which measured 113.7 degrees fahrenheit.
On 3/14/2023 identified staff was educated on the importance of water temperatures to not exceed 120 degrees fahrenheit to ensure the safety of the residents.
Within 30 days of the receipt of plan of correction: a tracking system was implemented to ensure that the water temperatures do not exceed 120 degrees fahrenheit. This will be done on random rooms weekly for 1 month then monthly for 6 month Documentation will be kept in TELS system.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented (- 06/14/2023)

103e - Left Overs

9. Requirements

103e - Left Overs *(continued)*

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 3/8/23 at 9:52 a.m., there was an unlabeled, undated plastic container of spaghetti and meatballs in the main kitchen's walk-in refrigerator.

Plan of Correction ***Accept (- 04/28/2023)***

The following corrective action was completed at time of survey on 3/8/2023. The unlabeled and undated container of spaghetti and meatballs in the main kitchen were thrown away.
On 3/9/2023 identified staff were educated on the correct way to properly label and date food. Documentation kept.
Within 30 days of receipt of plan of correction: a tracking system will be implemented by a designated staff person to ensure that all food is dated and labeled correctly. This will be done daily for one month. documentation kept.

Licensee's Proposed Overall Completion Date: *04/14/2023*

Implemented (- 06/14/2023)

103f - Refrigerator/Freezer Temps

10. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 3/8/23 at 9:48 a.m., there was no thermometer in the small Sanyo refrigerator in the ground floor dining room's kitchenette.

On 3/8/23 at 10:12 a.m., the temperature in the secure dementia care unit's (SDCU) refrigerator was 56 degrees Fahrenheit.

Plan of Correction ***Accept (- 04/28/2023)***

The following corrective action was completed at time of survey on 3/8/2023. A thermometer was placed in small Sanyo refrigerator in the ground flor dining room kitchenette.
The following corrective action was completed at time of survey on 3/8/2023. The temperature in M.C. refrigerator was lowered. The temperature was taken at 3:30pm and showed that the temperature was 39 degrees fahrenheit.
On 3/8/2023 the designated staff person checked all refrigerators and freezers to ensure an operable thermometer is present.
On 3/9/2023 identified staff were educated on the importance of monitoring all refrigerators and freezers to ensure that all food items are stored at safe temperatures. documentation kept.
on 3/9 2023 a designated staff person will monitor temperatures in kitchen freezer and refrigerator and kitchenette daily to ensure all food items are stored at safe temperatures. documentation will be kept.
if a refrigerator is found to be over 40 degrees fahrenheit or freezer is over 0 degrees fahrenheit, the food shall be immediately removed and stored at proper temperature in accordance with 2600.103f until repairs are made.

See attached.

Licensee's Proposed Overall Completion Date: *04/17/2023*

Implemented (- 06/14/2023)

103i - Outdated Food

11. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 3/8/23 at 9:52 a.m., there were 2 glass bowls of uncovered and unlabeled ice cream in the main kitchen's walk-in freezer.

Plan of Correction ***Accept (- 04/28/2023)***

The following corrective action was completed at time of survey on 3/8/2023. The two glass bowls of uncovered and unlabeled ice cream in the main kitchen's walk in freezer were thrown out.
3/9/2023 identified staff were educated on the correct way to properly label and date food. Documentation kept.
Within 30 days of receipt of plan of correction: a tracking system will be implemented by a designated staff person to ensure that all food is dated and labeled correctly. This will be done daily for one month. documentation kept.

See attached.

Licensee's Proposed Overall Completion Date: *04/17/2023*

Implemented (- 06/14/2023)

132c - Fire Drill Records

12. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drills conducted on the following dates and times indicates the number of residents evacuated exceeded the number of residents in the home:

- *2/20/22 at 8:31 a.m., 37 residents were in the home, 39 residents were evacuated*
- *3/10/22 at 10:24 p.m., 40 residents were in the home, 43 residents were evacuated*
- *4/21/22 at 12:21 p.m., 43 residents were in the home, 44 residents were evacuated*

Plan of Correction ***Accept (- 05/16/2023)***

On 3/14/2023 identified staff was educated on documentation of the fire log. Documentation kept.
On 3/14/2023 a fire safety expert conducted a evacuation fire drill for 2023. documentation kept.
On 5/26/2023 resident education on evacuation policies and procedures will be presented at resident council. documentation will be kept.
Starting on 5/10/2023 designated staff person will audit fire drill log to ensure that the log in complete and accurate with the number of residents that were evacuated. documentation completed.
Within 30 days of receipt of plan correction: The home will conduct 2 unannounced fire drills per month for the next 2 months documentation will be kept.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Implemented (- 06/14/2023)

132d - Evacuation

13. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill conducted on 12/30/22 at 5:00 a.m., the evacuation time was 16 minutes 15 seconds, which exceeds the maximum safe evacuation time of 15 minutes designated within the past year by a fire safety expert.

Multiple resident and staff interviews indicate that not all residents in the home are evacuated to a fire safe area or designated meeting place away from the building during fire drills.

Plan of Correction ***Accept ([redacted] - 05/16/2023)***

On 3/14/2023 a fire safety expert conducted a evacuation fire drill for 2023. documentation kept.
On 3/14/2023 identified staff were educated on the fire safe areas and evacuation policies and procedures documentation kept.
Within 30 days of receipt of plan correction: resident education on evacuation policies and procedures will be presented at resident council. documentation will be kept.
Within 30 days of receipt of plan correction: The home will conduct 2 unannounced fire drills per month for the next 2 months documentation will be kept.
On 5/26/2023 resident education on evacuation policies and procedures will be presented at resident council. documentation will be kept.
Starting on 5/10/2023 designated staff person will audit fire drill log to ensure that the log in complete and accurate with the number of residents that were evacuated. documentation completed.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Implemented ([redacted] - 06/14/2023)

141a 1-10 Medical Evaluation Information

14. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

141a 1-10 Medical Evaluation Information *(continued)*

Description of Violation

Resident #1's initial medical evaluation, dated [redacted]/22, did not include the resident's height. This area of the form was blank.

Plan of Correction ***Accept ([redacted] - 05/16/2023)***

The following corrective action was completed at time of survey on 3/8/2023. The height was added to resident #1 DME and initialed by nurse. documentation kept.
3/20/2023 the designated staff person reviewed all resident DME's to ensure that each has an accurate DME and is completed in its entirety, including the height.
On 3/17/2023 all staff persons completing DME's were educated on the completion of the resident DME's are completed. documentation kept.
On 3/20/2023 a designated staff person developed and implemented a system to ensure resident DME's are completed monthly for 6 months. Documentation kept.
On 5/10/2023 a designated staff person implemented a system to ensure that all new admissions were in compliance with regulation 2600.141a. documentation kept.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Implemented ([redacted] - 06/14/2023)

183d - Prescription Current

15. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 3/8/23, [redacted], prescribed for resident #2, was in the home's medication cart; however, the medication was discontinued on 3/1/23.

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

The following corrective action was identified at time of survey on 3/8/2023. [redacted] prescribed for resident #2 was taken out of cart and properly disposed of.
On 3/20/2023 mech techs and nurses were educated on the 6 rights of medication administration and how to do a med cart audit. documentation kept.
on 3/20/2023 a tracking system was developed and implemented by a designated staff person for med cart audits to be done weekly for 3 months then month y for 6 months. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *04/17/2023*

Implemented ([redacted] - 06/14/2023)

183e - Storing Medications

16. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 3/8/23, resident #2's [redacted] insulin pen was stored in the medication cart; however, the pen was not

183e - Storing Medications (continued)

labeled with the date it was opened.

Plan of Correction ***Accept (- 04/28/2023)***

The following corrective action was completed at time of survey on 3/8/2023. Order written for new insulin pen. documentation kept

On 3/20/2023 mech techs and nurses were educated on the 6 rights of medication administration and how to do a med cart audit. documentation kept.

on 3/20/2023 a tracking system was developed and implemented by a designated staff person for med cart audits to be done weekly for 3 months then monthly for 6 months. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *04/19/2023*

Implemented (- 06/14/2023)

184a - Resident's Meds Labeled

17. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #4 is prescribed [redacted]-Give 1 tablet by mouth two times a day [redacted], hold if pulse is less than 60; however, on 3/8/23 the pharmacy label did not include the instructions to hold if pulse less than 60.

REPEAT VIOLATION: 9/28/2021 et al.

Plan of Correction ***Accept (JK - 04/28/2023)***

The following corrective action was completed at time of inspection on 3/9/2023.
An order was obtained for the label on prescription and instruction to match match. documentation kept..
On 3/20/2023 mech techs and nurses were educated on the 6 rights of medication administration and how to do a med cart audit. documentation kept.

on 3/20/2023 a tracking system was developed and implemented by a designated staff person for med cart audits to be done weekly for 3 months then monthly for 6 months. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *04/19/2023*

Implemented (- 06/14/2023)

185a - Implement Storage Procedures

18. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 3/8/23, resident #1's glucometer was not calibrated to the correct time.

On the following dates, resident #2's blood sugar readings on her glucometer did not match the blood sugar readings

185a - Implement Storage Procedures (continued)

documented on the resident's March 2023 medication administration record (MAR):

Date	Time	Glucometer reading	MAR
3/1/23	8:00 a.m.	[redacted]	[redacted]
3/4/23	4:00 p.m.		
3/5/23	12:00 p.m.		

Plan of Correction ***Accept (JK - 05/16/2023)***

On 3/20/23 identified staff was educated on glucose monitoring machine and instructed about checking that date and time are correct. Documentation kept.
On 3/20/23 a designated staff person reviewed glucose monitoring to ensure that date and time were correct. documentation kept.
On 5/10/2023 a designated staff person implemented a monthly tracking system to ensure that the date and time are accurate on all individual glucose monitoring systems to be in compliance with 185a. New residents will be added to the checklist upon admission. Documentation kept.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Implemented ([redacted] - 06/14/2023)

187b - Date/Time of Medication Admin.

19. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On 3/13/23 at 9:29 a.m., resident #1's morning medications were in a plastic medication cup on [redacted] nightstand; however, the resident's March 2023 MAR indicates the medications were administered by staff person D at 8:00 a.m.

Plan of Correction ***Accept ([redacted] - 05/16/2023)***

The following corrective action was completed at time of survey on 3/13/2023. The pills from the night stand were removed
.On 3/20/2023 mech techs and nurses were educated on the 6 rights of medication administration and how to do a med cart audit documentation kept.
on 3/20/2023 a tracking system was developed and implemented by a designated staff person for med cart audits which includes auditing of emars for accuratecy and completeness. to be done weekly for 3 months then monthly for 6 months. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Implemented ([redacted] - 06/14/2023)

187d - Follow Prescriber's Orders

20. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed [redacted] 5mg tablets-Take 1 tab by mouth every morning. However, the resident is administered 10mg tablets, cut in half, with the remaining half destroyed.

187d - Follow Prescriber's Orders (continued)

Resident #2 is prescribed [redacted] kwikpen 100unit/1mL insulin pen-Inject sub-q as directed per sliding scale coverage, >200-399 inject 7 units; and >400 inject 9 units; however, the medication available on the medication cart is a [redacted] vial.

Plan of Correction ***Accept ([redacted] - 05/16/2023)***

The following corrective action was completed at time of survey on 3/8/2023. Order written for new insulin pen. documentation kept.
On 3/20/2023 mech techs and nurses were educated on the 6 rights of medication administration and how to do a med cart audit. doc. kept.
On 5/10/2023 a designated staff person implemented a tracking system for med cart audits and E-mar audit to ensure that the home is in compliance with regulation 187d. Audit will be done weekly for 3 months then monthly for 6 months. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Implemented ([redacted] - 06/14/2023)

227c - Support Plan Revision

21. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #4 uses a [redacted] however, the resident's most recent support plan, dated 8/2/22, does not indicate the use [redacted].

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

The following corrective action was completed at time of inspection on 3/9/2023. An addendum was completed and attached to 8/2/2022 assessment/SP.
On 3/17/2023 a designated staff person reviewed all current resident assessments to ensure that each resident had an accurate assessment of their turning/positioning needs. documentation kept.
on 3/20/2023 designated staff person developed and implemented a tracking system to ensure resident assessments are updated and accurate as resident needs change. Documentation kept.

Licensee's Proposed Overall Completion Date: *04/19/2023*

Implemented ([redacted] - 06/14/2023)

231b - Medical Evaluation

22. Requirements

231b - Medical Evaluation *(continued)*

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the SDCU on [redacted]/22; however, the resident s initial medical evaluation was completed on [redacted]/22. In addition, the attached medication list is dated [redacted]/23.

Resident #3 was admitted to the SDCU on [redacted]22; however, the resident s initial medical evaluation was completed on [redacted]23. In addition, the attached medication list is dated [redacted]/23.

REPEAT VIOLATION: 9/28/2021 et al.

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

On 3/20/2023 the designated staff person reviewed all resident records for those residents who reside on the secured dementia care unit to ensure that each resident medical evaluation was completed within 60 days prior to admission, Documentation kept.
On 3/20/2023 the designated staff person developed and implemented a system to ensure that each resident admitted to the secured dementia unit has a medical evaluation completed and dated within 60 days prior to admission. Documentation kept.
On 3/17/2023 identified staff was educated on regulation 231b.

Licensee's Proposed Overall Completion Date: *04/19/2023*

Implemented ([redacted] 06/14/2023)

234a - Admission Support Plan

23. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #2 was admitted to the SDCU on [redacted]22. However, the resident's initial support plan was completed on [redacted]/22.

REPEAT VIOLATION: 9/28/2021 et al.

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

On 3/20/2023 the designated staff person reviewed all resident records for those residents who reside on the secured dementia care unit to ensure that each resident support plan was completed within 72 hours prior to admission, Documentation kept.
On 3/20/2023 the designated staff person developed and implemented a system to ensure that each resident admitted to the secured dementia unit has a support plan completed and dated within 72 hours prior to admission. Documentation kept.
On 3/17/2023 identified staff was educated on regulation 234a

Licensee's Proposed Overall Completion Date: *04/20/2023*

234a - Admission Support Plan *(continued)*

Implemented (- 06/14/2023)